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UNITED STATES PATENT AND TRADEMARK OFFICE

BEFORE THE BOARD OF PATENT APPEALS
AND INTERFERENCES

Ex parte GLENN PHILANDER VONK, ANN K. FRANTZ, DAVID JOSHUA WHELLAN, CHRISTOPHER MICHAEL O'CONNOR, and GEORGE B. GOLDMAN

Appeal 2009-003953
Application 09/881,041
Technology Center 3600

Decided:[1] July 28, 2009

Before HUBERT C. LORIN, ANTON W. FETTING, and JOSEPH A. FISCHETTI, *Administrative Patent Judges.*

FETTING, *Administrative Patent Judge.*

DECISION ON APPEAL

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[1] The two month time period for filing an appeal or commencing a civil action, as recited in 37 C.F.R. § 1.304, begins to run from the decided date shown on this page of the decision. The time period does not run from the Mail Date (paper delivery) or Notification Date (electronic delivery).

STATEMENT OF THE CASE

Glenn Philander Vonk, Ann K. Frantz, David Joshua Whellan, Christopher Michael O'Connor, and George B. Goldman (Appellants) seek review under 35 U.S.C. § 134 (2002) of a final rejection of claims 1-25, the only claims pending in the application on appeal.

We have jurisdiction over the appeal pursuant to 35 U.S.C. § 6(b) (2002).

We AFFIRM and ENTER A NEW GROUND OF REJECTION PURSUANT TO 37 C.F.R. § 41.50(b).

The Appellants invented a system and method for healthcare managers and healthcare providers to interactively cooperate with patients to monitor and evaluate patient status to provide the most appropriate treatment for the patients in the most cost-effective manner (Specification ¶ 0003).

An understanding of the invention can be derived from a reading of exemplary claims 1, 8, 15, 21, and 22, which are reproduced below [bracketed matter and some paragraphing added].

> 1. A system for monitoring health-related conditions of patients, comprising:
> [1] a plurality of remote monitoring stations, each being configured to receive patient health-related data pertaining to a respective patient; and
> [2] a computer network comprising a database containing accumulated health-related data pertaining to health-related conditions and treatments that reveals population trends and outcomes and at least one data access device configured to provide a health care provider access to said computer network and said database, said computer network configured to receive said patient health-related data pertaining to respective patients from said remote monitoring stations and provide a health care provider with electronic treatment establishment tools to establish treatment programs for said patients based on their

respective patient health-related data and said accumulated health-related data, and said computer network configured to revise said accumulated health-related data based on said patient health-related data for identification of improvements in standards of care and medical practices that can be made for different ones of the health-related conditions;

[3] said remote monitoring stations being configured with electronic self-management tools for receiving from a respective patient said patient health-related data relating to integration of a selected one of said treatment programs into the patient's lifestyle comprising at least one of questions concerning health or treatment and responses to questions concerning health or treatment that are generated using said electronic self-management tools;

[4] said computer network being configured with electronic assessment tools to allow a health care provider to assess said patient health-related data to determine progress of the patient on the selected treatment program and whether information relating to the selected treatment program needs to be conveyed to the patient in response to said progress determination.

8. A method for monitoring health-related conditions of patients, comprising:

[1] obtaining patient health-related data pertaining to patients at a plurality of remote monitoring stations, each being configured to receive respective said patient health-related data from a respective said patient;

[2] storing accumulated health-related data pertaining to health-related conditions and treatments that reveals population trends and outcomes in a database of a computer network;

[3] receiving at said computer network said patient health-related data from said remote monitoring stations pertaining to respective patients;

[4] controlling said computer network to provide a health care provider with electronic treatment establishment tools to establish treatment programs for said patients based on their respective patient health-related data and said accumulated health-related data;

[5] controlling said computer network to revise said accumulated health-related data based on said patient health-related data;
[6] generating from said accumulated health-related data clinical data comprising outcomes of said treatment programs;
[7] receiving economic data relating to protocols used in said treatment programs;
[8] aggregating said patient health-related data, said clinical data and said economic data with said accumulated health-related data comprising population outcomes and generic standards of care; and
[9] determining from said aggregated data recommendations for improving the treatment programs.

15. A method for managing health-related conditions of patients, comprising:
[1] assigning healthcare managers to said patients, such that each said healthcare manager is assigned to a respective group of said patients;
[2] collecting healthcare data by using each said healthcare manager to collect respective patient health-related data for each respective patient in their said group of patients;
[3] determining whether each respective patient is suitable for participation in a treatment program;
[4] controlling a computer network to receive said health-related data from each of said healthcare managers, and to store said patient health-related data pertaining to each said patient in a database, said database further including accumulated data pertaining to health-related conditions and treatments that reveals population trends and outcomes;
[5] coordinating each said healthcare manager with at least one member of a primary care team to establish a treatment program for each respective patient in their said group of patients based on said patient health-related data pertaining to that respective patient and said accumulated data; and
[6] updating said accumulated data in said database based on said patient health-related data provided by said healthcare managers and identifying improvements in standards of care

and medical practices that can be made for different ones of the health-related conditions;

[7] wherein the determining step comprises the steps of

[a] obtaining agreement from a respective patient to participate in a treatment program; and

[b] receiving approval from a payer who will pay for the treatment program;

[8] wherein the controlling step comprises the steps of

[a] receiving health-related data for a respective patient comprising assessment of the patient's medical, psychosocial and environmental conditions;

[b] receiving a plan of care initiated by the corresponding one of the healthcare managers assigned to the patient as a result of an interview with the patient and the assessment, the plan of care being used in the establishment of the treatment program for the patient.

21. A method as claimed in claim 15, wherein collecting healthcare data comprises said healthcare managers developing a client plan of care (CPOC) and a medical plan of care (MPOC), the CPOC is developed during the interview with the patient, and the MPOC is developed with at least one member of the primary care team.

22. A method as claimed in claim 15, wherein the determining comprises excluding a respective patient based on selected criteria comprising the patient is a minor, the patient has not received a selected diagnosis, and the patient cannot communicate effectively, and including a respective patient based on selected criteria comprising having a selected primary diagnosis, and being at risk for future hospital admissions.

This appeal arises from the Examiner's Final Rejection, mailed August 22, 2007. The Appellants filed an Appeal Brief in support of the appeal on April 22, 2008. An Examiner's Answer to the Appeal Brief was mailed on August 6, 2008. A Reply Brief was filed on October 6, 2008.

PRIOR ART

The Examiner relies upon the following prior art:

Russek	US 5,319,355	Jun. 7, 1994
Seare	US 5,557,514	Sep. 17, 1996
Ballantyne	US 5,867,821	Feb. 2, 1999
Summerell	US 5,937,387	Aug. 10, 1999
Joao	US 6,283,761 B1	Sep. 4, 2001
Soll	US 2003/0055679 A1	Mar. 20, 2003

REJECTIONS

Claims 1-7 stand rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell.

Claims 8-14 stand rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare.

Claims 15-21 and 23-25 stand rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll.

Claim 22 stands rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Soll, and Official Notice.

ISSUES

The issues pertinent to this appeal are

- Whether the Appellants have sustained their burden of showing the Examiner erred in the rejection of claims 1-7 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell.
    - This pertinent issue turns on whether Ballantyne and Joao fail to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and

outcomes and the revision of data to identify improvements in standards of care and medical practices.

- Whether the Appellants have sustained their burden of showing the Examiner erred in the rejection of claims 8-14 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare.
    - This pertinent issue turns on whether Ballantyne and Joao fail to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices.
- Whether the Appellants have sustained their burden of showing the Examiner erred in the rejection of claims 15-21 and 23-25 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll.
    - This pertinent issue turns on whether Ballantyne and Joao fail to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices.
- Whether the Appellants have sustained their burden of showing the Examiner erred in the rejection of claim 22 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Soll, and Official Notice.
    - This pertinent issue turns on whether the Examiner's Official Notice failed to address the limitation of excluding a patient

from a treatment program based on criteria that the patient cannot communicate effectively.

FACTS PERTINENT TO THE ISSUES

The following enumerated Findings of Fact (FF) are believed to be supported by a preponderance of the evidence.

Ballantyne

01. Ballantyne is directed to a method and apparatus for the distribution of information that is useful in any healthcare facility (Ballantyne 1:13-16).

02. Ballantyne describes the medical information network to consist of a master library, a communications interconnection system, distributed processing nursing stations, individual bedside patient care stations, and integrated personal data assistants (Ballantyne 3:60-67 and fig. 1).

03. A Personal Care Station (PCS) facilitates the interaction between a patient or the medical staff and the master library (Ballantyne 8:66-67).

04. The PCS is integrated with a smart health card reader/writer (Ballantyne 15:41-42). The health card contains personal data, emergency data, medical history data, and present examination data (Ballantyne 15:50 – 16:13). The personal data includes name, address, next of kin, DOB, and insurance information (Ballantyne 15:50-55). The emergency data includes data of life saving importance such as blood type, allergies, medications, and immediate medical history (Ballantyne 15:56-62). The medical

history contains information on the past medical history of the patient including past diseases, injuries, operations, and associated treatments (Ballantyne 15:63-67). The present examination data includes information relating to the actual examination, who performed the examination, where and when it was performed, and the diagnosis and treatment prescribed based on the examination (Ballantyne 16:6-13).

Summerell

05. Summerell is directed to a system and method for determining a user's physiological age based on a combination of health risk and health enhancing factors (Summerell 1:8-12).

06. Summerell describes a wellness system that collects voluntary information from a user, measures the users wellness by determining the user's physiological age, provides the user with expert knowledge on how to improve the user's wellness, enables the user to select from various options to improve the user's wellness, and monitors the user's progress towards wellness (Summerell 4:42-47).

07. Summerell also describes that the wellness system can be used in conjunction with pre- and post- surgery (Summerell 6:1-13). Surgeons and anesthesiologists can describe to a user the effects of smoking on a patient undergoing arterial reconstruction (Summerell 6:1-13). The health care facility can use the wellness system to monitor the patients progress (Summerell 6:1-13).

Joao

08. Joao is directed to an apparatus and method for providing and processing healthcare-related information (Joao 1:16-21).

09. Joao maintains information related to the success and failures of treatment plans (Joao 17:40-41).

10. Joao describes an apparatus and method that can be utilized for determining and/or ascertaining a medical diagnosis, verifying and/or checking a diagnosis or treatment, or performing a self-diagnosis (Joao 4:33-39). Joao further describes the evaluation and verification of diagnoses, treatments, and any other part of providing healthcare services (Joao 9:57-10:2). The verification of a diagnosis requires determining the correctness of that diagnosis (Joao 24:2-8 and 25:5-9).

11. Joao describes that a provider will access the central processing computer and input patient information (Joao 25:11-14). The central processing computer determines whether any medical history for the patient exists and retrieves or requests a medical history for the patient based on that determination (Joao 25:13-19).

12. Then the patient's symptoms and examination findings are obtained from the patient and transmitted to the central processing computer (Joao 25:25-30). The central processing computer then processes the patient's symptoms and examination findings in conjunction with the patient's medical history (Joao 25:30-35).

13. After processing this information, the central processing computer will perform a comprehensive diagnostic evaluation of the patient (Joao 25:35-38). The central processing computer will

output this evaluation into a diagnostic report (Joao 25:40-42). The report includes a single diagnosis or a list of possible diagnoses, the respective probabilities of occurrence, and the corresponding statistical information (Joao 25:43-46). The diagnosis may include medical information, textbook materials, laboratory materials, reference materials, video clips, hyperlinks to informational sources, and other relevant information (Joao 26:11-19).

14. The central processing computer will further generate a treatment report that considers possible drug interactions and/or treatment interactions (Joao 25:49-53).

15. The central computer then transmits the diagnostic report and treatment report to a medical doctor and the medical doctor can choose a final diagnosis for the patient (Joao 25:54-62). The doctor transmits the final diagnosis and/or treatment plan to the central processing computer (Joao 25:63-66). The central processing computer updates the patient's medical record based on the reports (Joao 25:66-67).

16. The system can further be utilized to perform treatment evaluations and monitor treatment plans (Joao 27:58-67). The system can be accessed by providers, payers, patients, users, or intermediaries in order to evaluate treatments (Joao 27:58-67). The central processing computer generates an evaluation report and transmits this report to a payer for the services in order to assist the payer in determining whether to submit payment for the services (Joao 28:38-60).

17. Joao further describes that providers can access the central processing computer to find specific services (Joao 30:60-67). The system will respond to a request from the provider and identify a medical specialist that can perform the requested medical services (Joao 30:60-67). The provider can additionally request the central processing computer to identify a facility (Joao 31:5-6), a payer (Joao 31:10-11), supplies (Joao 31:26-27), and other services or items required for the care of a patient.

18. Joao maintains a database that stores statistical data on information regarding diagnoses, alternate diagnoses, treatment success, treatment failure, misdiagnoses, and the success and failure of experimental treatments (Joao 20:13-19). Joao further uses this statistical information in the generation of a diagnostic report that enables a physician to make a final diagnosis determination (Joao 25:41-47). All of the data in the database can be updated by any party so as to provide and ensure that the data is up-to-date (Joao 25:34-39).

Seare

19. Seare is directed to methods and systems for analyzing medical claim histories and billing patterns to statistically establish treatment utilization patterns (Seare 1:21-24).

20. Seare describes a system that creates a profile for end users that uses historical medical provider billing information (Seare 21:10-12). The preferred embodiment includes a minimum of two years of billing information and fifty million claims in order to develop

a profile (Seare 21:16-19). The system isolates and extrapolates relevant billing information (Seare 22:27-32).

21. After collecting this data, an episode of care (EOC) is determined for each diagnosis (Seare 23:6-8). An episode of care is defined as all of the healthcare services provided to a patient for the diagnosis, treatment, and aftercare for a specific medical condition (Seare 23:7-11).

22. All of the information analyzed and stored in the database can be presented to users in the form of reports (Seare 28:10-11).

Soll

23. Soll is directed to a system for disease management that enhances the quality and cost-effectiveness of healthcare (Soll ¶ 1).

24. Soll describes a system that interviews a patient to collect, store, and analyze the patient's health information (Soll ¶ 51). The information is reported to a physician to assist the physician assessing the patient and in diagnostic decision making (Soll ¶ 51). Upon completion of the physician assessment, the physician inputs a patient management plan that includes educational materials regarding the selected treatments (Soll ¶'s 51 and 163-180).

Russek

25. Russek is directed to a communications and alarm system for providing secure and reliable patient monitoring (Russek 1:10-12).

26. Russek describes that the scheduling information in the system includes a list of the hospital staff that are assigned to specific patients (Russek 9:28-32).

Facts Related To The Level Of Skill In The Art

27. Neither the Examiner nor the Appellants has addressed the level of ordinary skill in the pertinent art of healthcare treatment, diagnoses, and management systems. We will therefore consider the cited prior art as representative of the level of ordinary skill in the art. *See Okajima v. Bourdeau*, 261 F.3d 1350, 1355 (Fed. Cir. 2001) ("[T]he absence of specific findings on the level of skill in the art does not give rise to reversible error 'where the prior art itself reflects an appropriate level and a need for testimony is not shown'") (quoting *Litton Indus. Prods., Inc. v. Solid State Sys. Corp.*, 755 F.2d 158, 163 (Fed. Cir. 1985)).

Facts Related To Secondary Considerations

28. There is no evidence on record of secondary considerations of non-obviousness for our consideration.

PRINCIPLES OF LAW

Obviousness

A claimed invention is unpatentable if the differences between it and the prior art are "such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art." 35 U.S.C. § 103(a) (2000); *KSR Int'l Co. v. Teleflex Inc.*, 550 U.S. 398, 406 (2007); *Graham v. John Deere Co.*, 383 U.S. 1, 13-14 (1966).

In *Graham*, the Court held that the obviousness analysis is bottomed on several basic factual inquiries: "[(1)] the scope and content of the prior art are to be determined; [(2)] differences between the prior art and the claims at issue are to be ascertained; and [(3)] the level of ordinary skill in the pertinent art resolved." 383 U.S. at 17. *See also KSR*, 550 U.S. at 406. "The combination of familiar elements according to known methods is likely to be obvious when it does no more than yield predictable results." *Id.* at 416.

"When a work is available in one field of endeavor, design incentives and other market forces can prompt variations of it, either in the same field or a different one. If a person of ordinary skill can implement a predictable variation, § 103 likely bars its patentability." *Id.* at 417.

"For the same reason, if a technique has been used to improve one device, and a person of ordinary skill in the art would recognize that it would improve similar devices in the same way, using the technique is obvious unless its actual application is beyond his or her skill." *Id.*

"Under the correct analysis, any need or problem known in the field of endeavor at the time of invention and addressed by the patent can provide a reason for combining the elements in the manner claimed." *Id.* at 420.

ANALYSIS

Claims 1-7 rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell

The Appellants argue these claims as a group.

Accordingly, we select claim 1 as representative of the group. 37 C.F.R. § 41.37(c)(1)(vii) (2008).

The Examiner found that Ballantyne describes limitations [1] and [2] of claim 1, but fails to describe limitations [3] and [4] (Ans. 3-4). The Examiner found that Summerell describes limitation [3] and Joao describes limitation [4] (Ans. 5). The Examiner further found that a person of ordinary skill in the art would have recognized the benefits of facilitating healthcare services by providing access to information in order to determine the progress of a patient and by providing self-monitoring equipment as described by Summerell and Joao (Ans. 5-6). The Examiner found that a person with ordinary skill in the art would have found it obvious to combine Ballantyne, Joao, and Summerell (Ans. 5-6).

The Appellants contend that (1) Ballantyne fails to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices (Br. 8-9 and Reply Br. 6-7), (2) Summerell fails to describe limitation [3] of claim 1(Br. 10 and Reply Br. 10-12), and (3) Joao fails to describe determining whether information relating to a selected treatment program needs to be conveyed to the patient in response to progress determination as required by limitation [4] of claim 1 (Reply Br. 12-13).

The Appellants first contend that (1) Ballantyne fails to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices (Br. 8-9 and Reply Br. 6-7). Ballantyne describes a system for distributing and managing health-related information between the patient and healthcare service providers (FF 03) but fails to specifically describe data pertaining to health-

related conditions and treatments that reveal population trends and outcomes as required by limitation [2] of claim 1.

The Examiner found that the limitation directed to revealing population trends and outcomes is merely an intended use (Ans. 24); however, this limitation should be given patentable weight as it further limits the scope of the data. The Examiner further found that the limitation for identifying improvements also should not be given patentable weight because it is a mere intended use of the claimed invention (Ans. 24); however, the identifying of improvements should be given patentable weight because it is a functional step that further limits the scope of the invention. As such, the Appellants' arguments that the one reference, Ballantyne, fails to describe these limitations have validity.

However, the Appellants overlook the fact that another reference, Joao, describes health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices. Joao describes storing health-related data and statistical information regarding diagnoses and treatment outcomes in a database (FF 11 and FF 18). The statistical information is further applied towards patient health-related data in order to more accurately determine a diagnosis and treatment plan (FF 18). Statistical information reflects trends in the diagnoses and treatments of several patients. Joao further describes that all of the health-related data stored in the database can be updated such that all of the data is up-to-date and comprehensive (FF 18).

The updating of the health-related information will also update the statistical information on diagnoses and treatments and thereby will also

identify improvements in diagnoses and treatments by applying up-to-date statistics. A person with ordinary skill in the art would have recognized the benefit of using a statistical analysis of patient health-related data in the diagnoses and treatment of patients and updating the statistics used in order to improve the resulting diagnoses and treatments generated. As such, Joao describes these features and a person with ordinary skill in the art would have been motivated to combine these features described by Joao with Ballantyne in order to increase the accuracy of the diagnoses and treatments generated.

The Appellants next contend that (2) Summerell fails to describe limitation [3] (Br. 10 and Reply Br. 10-12). The Appellants specifically contend that Summerell does not describe that a healthcare provider creates the profile for the patient and a healthcare provider does not select a treatment plan as required by the antecedent basis found in limitation [2] (Br. 10-12 and Reply Br. 11-12).

We disagree with the Appellants. Limitation [3] requires receiving health-related information from a patient to be integrated into to a selected treatment plan (as recited by limitation [2]), where the information is obtained by asking the patient questions and using the responses given by the patient.

Summerell describes a wellness system that presents a patient with a set of questions and develops a physiological age for that patient based on the information provided by the patient (FF 06). Summerell further describes that a surgeon or anesthesiologist can selected a treatment program to present to the patient in order to encourage and motivate the user to progress pre- or post- surgery (FF 07). For example, a surgeon can present a

patient, who is undergoing arterial reconstruction, the effects of smoking on their physiological age (FF 07). Thus, the surgeon is selecting a treatment program on the wellness system for the patient. As per the Appellants' contention that the healthcare provider does not create the profile for the patient, there is nothing required in limitation [3] that requires a healthcare provider to create a treatment program by submitting the patient information as argued. As such, Summerell describes limitation [3].

The Appellants further contend that (3) Joao fails to describe determining whether information relating to a selected treatment program needs to be conveyed to the patient in response to progress determination as required by limitation [4] (Reply Br. 12-13). We disagree with the Appellants. Joao describes monitoring and evaluating the progress of a treatment (FF 16). Joao further describes that an evaluation report, which contains information regarding the progress and evaluation of a treatment, is transmitted to a payer (FF 16). This can be done in response to requesting payment for services rendered (FF 16). The payer for healthcare services can also be the patient receiving the healthcare services. Under the broadest reasonable interpretation, the payer/patient is being notified of the progress of treatment. As such, Joao does describe determining whether information regarding a treatment needs to be conveyed to a patient in response to a progress or evaluation determination as required by limitation [4].

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 1-7 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell.

Claims 8-14 rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare

The Appellants argue these claims as a group.

Accordingly, we select claim 8 as representative of the group.

The Examiner found that Ballantyne describes all of the limitations of claim 8 as discussed in the rejection of claim 1, except for limitations [6], [7], [8], and [9] (Ans. 10). The Examiner found that Joao describes limitation [6] and Seare describes limitations [7], [8], and [9] (Ans. 11). The Examiner further found that a person of ordinary skill in the art would have recognized the benefits of facilitating healthcare services by providing access to information in order to accurately determine the progress of a patient and by providing additional economic and health-related data to make determinations described by Seare and Joao (Ans. 11). The Examiner thus found that a person with ordinary skill in the art would have found it obvious to combine Ballantyne, Joao, and Seare (Ans. 11).

The Appellants contend that (1) Ballantyne, Joao, and Seare fail to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and revising said data based on patient health-related data and determining recommendations for improving treatment programs, as argued *supra* with respect to claim 1 (Br. 11), (2) Seare fails to describe receiving economic data relating to protocols used in these treatment programs as required by limitation [7] (Br. 12), and (3) Seare and Joao fail to describe clinical data comprising outcomes of the treatment programs (Br. 12).

The Appellants first contend that (1) Ballantyne, Joao, and Seare fail to describe health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and revising said data based on patient health-related data and determining recommendations for

improving treatment programs, as argued *supra* with respect to claim 1 (Br. 11). We find that Joao describes these limitations as discussed *supra* and denominate a new ground of rejection within the meaning of 37 C.F.R. § 41.50(b) for the same reasons discussed *supra*.

The Appellants also contend that (2) Seare fails to describe receiving economic data relating to protocols used in these treatment programs (Br. 12). We disagree with the Appellants. Limitation [7] requires receiving economic data associated with procedures in a treatment program. Seare describes compiling billing data received form various sources for each specific diagnosis (FF 20 and FF 21). That is, Seare is describing the cost information for each procedure used in the treatment of diagnoses. As such, Seare describes receiving economic data relating to protocols used in said treatment programs as required by limitation [7] of claim 8.

The Appellants further contend that (3) Seare and Joao fail to describe clinical data comprising outcomes of the treatment programs (Br. 12). We disagree with the Appellants. As discussed *supra*, Joao describes maintaining data that relates to the outcomes of treatment plans, including both the successes and failures of treatment programs (FF 09 and FF 10). Since limitation [6] defines clinical data to comprise the outcomes of treatment programs and Joao explicitly describes the storing the outcomes of treatment plans, Joao therefore describes this clinical data. The Appellants further contend that Seare fails to describe this limitation, however, the Examiner has only relied on Joao to describe this feature. As such, this contention presented by the Appellants does not persuade us of error on the part of the Examiner because the Appellants are responding to the rejection by attacking the references separately, even though the rejection is based on

the combined teachings of the references. Nonobviousness cannot be established by attacking the references individually when the rejection is predicated upon a combination of prior art disclosures. *See In re Merck & Co., Inc.*, 800 F.2d 1091, 1097 (Fed. Cir. 1986).

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 8-14 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare.

Claims 15-21 and 23-25 rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll

The Appellants argue these claims as a group.

Accordingly, we select claim 15 as representative of the group.

The Examiner found that Ballantyne describes limitations [1], [2], and [3] of claim 15 as discussed *supra* in the rejection of claim 1, but fails to describe limitations [4], [5], [6], [7], and [8] of claim 15 (Ans. 13-14). The Examiner found that Russek describes limitation [4], Joao describes limitations [5], [7b], and [8a], and Soll describes limitations [6], [7a], and [8b] (Ans. 14-15). The Examiner further found that a person with ordinary skill in the art would have recognized the benefits of facilitating healthcare services, providing efficient and reliable communications, and providing a system and method of healthcare by assigning resources to patients to develop treatment plans based on health-related data as described by Joao, Russek, and Soll (Ans. 15). The Examiner also found that a person with ordinary skill in the art would have found it obvious to combine Ballantyne, Joao, Russek, and Soll (Ans. 15).

The Appellants contend that (1) Ballantyne fails to describe accumulated health-related data and Ballantyne and Joao fail to describe updating accumulated health-related data based on patient health-related data or identifying improvements in standards of care as argued *supra* for claims 1 and 8 (Br. 13-15), (2) Soll fails to describe determining if a patient is suitable for participation in a treatment program as required by limitation [3] of claim 15 (Br. 14 and Reply Br. 18), (3) Joao fails to describe developing a client plan of care (CPOC) and a medical plan of care (MPOC) as required by claims 21 and 23 (Br. 14 and Reply Br. 19-20), and (4) Russek fails to describe coordinating each said healthcare manager with at least one member of a primary care team as required by limitation [5] of claim 15 (Reply Br. 18-19).

The Appellants first contend that (1) Ballantyne fails to describe accumulated health-related data and Ballantyne and Joao fail to describe updating accumulated health-related data based on patient health-related data or identifying improvements in standards of care as argued *supra* for claims 1 and 8 (Br. 13-15). We find that Joao describes these limitations as discussed *supra* and denominate a new ground of rejection within the meaning of 37 C.F.R. § 41.50(b) for the same reasons discussed *supra*.

The Appellants next contend (2) Soll fails to describe determining if a patient is suitable for participation in a treatment program (Br. 14). We disagree with the Appellants. Limitation [3] only requires determining whether a patient is suitable for a specific treatment plan. Soll describes collecting patient health information in order to assist a physician in determining an appropriate treatment (FF 24). Although the portion of Soll cited by the Examiner (Soll ¶ 58) does describe exit interviews subsequent to

the administration of a treatment program, Soll also describes assessing patient health information and enabling a physician to determine whether a treatment plan for the patient is appropriate (FF 24). The Appellants additionally contend that Soll fails to describe limitation [7][b], however, the Examiner has only relied on Joao to describe this feature. As such, this contention presented by the Appellants does not persuade us of error on the part of the Examiner because the Appellants are responding to the rejection by attacking the references separately, even though the rejection is based on the combined teachings of the references. *Id.*

The Appellants further contend that (3) Joao fails to describe developing a client plan of care (CPOC) and a medical plan of care (MPOC) as required by claims 21 and 23 (Br. 14 and Reply Br. 19-20). We disagree with the Appellants. Joao describes that a provider can use the central processing computer to identify a medical specialist to perform a medical service (FF 17). Thus, the provider is distinct from the medical specialist, or primary care team. The medical specialist diagnoses the patient and develops a treatment plan (FF 13). As such, the provider (or manager) is working with the medical specialist (or primary care team) to develop a treatment or medical care plan for the patient. Joao further describes that the provider, using the central processing computer, can identify and locate all other needs that a patient may have (FF 17). That is, the provider can systematically manage the needs of the patient, in addition to determining the medical care plan. The management of the patient's needs is a client care plan because it addresses all of the needs of the patient, including the medical care plan. As such, Joao does describe developing a client plan of care and a medical plan of care as required by claims 21 and 23.

The Appellants additionally contend that (4) Russek fails to describe assigning healthcare managers to said healthcare patients, such that each said healthcare manager is assigned to a respective group of patients as required by limitation [1] (Reply Br. 18-19). We disagree with the Appellants. Limitation [1] requires the assignment of a manager to a group of patients. Russek describes that scheduling information includes information regarding which hospital staff is assigned to specific patients (FF 26). The hospital staff includes personnel that are part of the hospital administrative staff, such as managers, and personnel that are part of the medical staff, such as nurses and doctors. As such, the association of staff to specific patients can include managers and therefore Russek does describe limitation [1].

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 15-21 and 23-25 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll.

Claim 22 rejected under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Soll and Official Notice

The Examiner found that Ballantyne, Joao, Russek, and Soll describe all of the limitations of claim 15, but fail to describe the additional limitations of claim 22 (Ans. 22). The Examiner found that the steps of including and excluding patients for various criteria, as required by claim 22, were old and well-known in the art at the time of the invention and as such the Examiner took Official Notice of these limitations (Ans. 22).

The Appellants contend that claim 22 recites excluding a patient from a treatment program based on criteria that the patient cannot communicate

effectively and the Examiner's Official Notice failed to address this limitation (Br. 15 and Reply Br. 20-21).

We disagree with the Appellants. The Examiner found that the steps of including patients for various criteria were old and well-known in the art (Ans. 22). The Examiner specifically found that the including and excluding based on various criteria *such those claimed* are old and well-known (Ans. 22). As such, the Examiner's taking of Official Notice does cover excluding a patient from a treatment program based on the criteria that the patient cannot communicate effectively.

Because claim 22 depends from claim 15 and claim 15 is rejected under a new ground of rejection, the rejection of claim 22 is also denominated as a new ground of rejection.

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claim 22 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Soll, and Official Notice.

CONCLUSIONS OF LAW

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 1-7 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell.

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 8-14 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare.

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claims 15-21 and 23-25 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll.

The Appellants have not sustained their burden of showing that the Examiner erred in rejecting claim 22 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Sol, and Official Notice.

New Ground Designation

Because we are applying the art in each of the independent claims in a manner different from that of the Examiner, with Joao describing the health-related data pertaining to health-related conditions and treatments that reveal population trends and outcomes and the revision of data to identify improvements in standards of care and medical practices, we denominate the above rejections as new grounds of rejection within the meaning of 37 C.F.R. § 41.50(b).

DECISION

To summarize, our decision is as follows:

- The rejection of claims 1-7 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Summerell is sustained.
- The rejection of claims 8-14 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, and Seare is sustained.
- The rejection of claims 15-21 and 23-25 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, and Soll is sustained.
- The rejection of claim 22 under 35 U.S.C. § 103(a) as unpatentable over Ballantyne, Joao, Russek, Soll, and Official Notice is sustained.
- The above rejections are denominated as new grounds of rejection within the meaning of 37 C.F.R. § 41.50(b).

This Decision contains a new rejection within the meaning of 37 C.F.R. § 41.50(b) (2008).

Our decision is not a final agency action.

37 C.F.R. § 41.50(b) provides that the Appellant, WITHIN TWO MONTHS FROM THE DATE OF THE DECISION, must exercise one of the following two options with respect to the new rejection:

> (1) *Reopen prosecution*. Submit an appropriate amendment of the claims so rejected or new evidence relating to the claims so rejected, or both, and have the matter reconsidered by the Examiner, in which event the proceeding will be remanded to the Examiner. . . .
> (2) *Request rehearing*. Request that the proceeding be reheard under § 41.52 by the Board upon the same record. . . .

No time period for taking any subsequent action in connection with this appeal may be extended under 37 C.F.R. § 1.136(a). *See* 37 C.F.R. § 1.136(a)(1)(iv) (2008).

AFFIRMED; 37 C.F.R. 41.50(b)

hh

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